GENERAL AMENDMENT
FOR THE FOLLOWING VENDORS:

VOLUNTEER STATE HEALTH PLAN
UNISON HEALTH PLAN OF TENNESSEE
JOHN DEERE
PREFERRED HEALTH PLAN
WINDSOR HEALTH PLAN d.b.a. VHP, INC.
MEMPHIS MANAGED CARE CORPORATION

(General)**AMENDMENT NUMBER 10**

AMENDED AND RESTATED CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
CONTRACTOR NAME,
d.b.a.

CONTRACT NUMBER: FA-

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Amended and Restated Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and Contractor Name, hereinafter referred to as the CONTRACTOR as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1-3 shall be amended by deleting and replacing the definitions for "Medical Expenses" and "Medically Necessary" so that the amended definitions shall read as follows:

   Medical Expenses (sometimes referred to as "Covered Services") - Consist of the following:

   a. The cost of providing TennCare Program medical services to enrollees as identified below and pursuant to the following listed subsections of Section 2-3 of the CRA:

      1. 2-3.a Covered Services
      2. 2-3.c Specialized Services
      3. 2-3.h Use of Cost Effective Alternative Services
      4. 2-3.o Coverage of Sterilization's, Abortions and Hysterectomies pursuant to applicable federal and state laws and regulations
      5. 2-3.p Coverage of Organ and Tissue Transplants
      6. all services related to hospice
      7. capitated payment to licensed health care providers
      8. medical services directed by TENNCARE or an Administrative Law Judge
      9. net impact of reinsurance coverage purchased by the MCO

   b. Preventive Services: In order for preventive services in Section 2-3 (including, but not limited to, health education, and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR's enrollees or targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs must be approved by TENNCARE.

   c. Medical case management may qualify as medical expenses if the service is targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs is approved by TENNCARE.

   d. Medical Expenses do not include:

      1. 2-4. Services Not Covered;
      2. 2-3.f. Institutional Services and Alternatives to Institutional Services;

3. Services eligible for reimbursement by Medicare;
4. The activities described in or required to be conducted in Attachments I, II, III, IV, V, VI, VII, XI, XII, XIII (including, but not limited to, utilization management, utilization review activities) are administrative costs; and
5. The two percent HMO tax.

e. Medical expense will be net of any TPL recoveries or subrogation activities. If approved by TENNCARE, the TPL or subrogation recoveries may be net of administrative expenses incurred that are related to recovery activities.

e. Medical expense will be net of any pharmacy rebates.

f. This definition does not apply to NAIC filings.

Medically Necessary – Shall be defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in regulations at 1200-13-16-.01, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in regulations at 1200-13-16-.01.

2. Section 1-5.a.4 shall be deleted in its entirety and replaced by a new Section 1-5.a.4 which shall read as follows:

1-5.a.4. The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, , the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:

i. contact the subject of the investigation about any matters related to the investigation,
ii. enter into or attempt to negotiate any settlement or agreement regarding the incident, or
iii. accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident. .

3. Section 2-3.a.1(b) shall be deleted and replaced in its entirety so that the amended Section 2-3.a.1(b) shall read as follows:

2-3.a.1(b) TennCare Benefits, effective July 1, 2006:

Should TENNCARE eliminate a specified population from eligibility in the TennCare Program, Services/Benefits listed below shall no longer be applicable for said population.

SERVICE	BENEFIT
Inpatient Hospital Services	**Medicaid/Standard Eligible, Age 21 and older:** As medically necessary. Inpatient rehabilitation hospital facility services are Not covered for adults. May be provided by the CONTRACTOR if determined by the CONTRACTOR to be a cost effective alternative. **Medicaid/Standard Eligible, Under age 21**: As medically necessary, rehabilitation hospital facility services are covered under EPSDT for Medicaid eligible children and as medically necessary for Standard eligible children.
Outpatient Hospital Services	**As medically necessary.**
Physician Inpatient Services	**As medically necessary.**
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	**As medically necessary.** **NOTE:** CONTRACTOR covered services shall include the following: • Services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). • Behavioral health services described in CPT procedure code range 96150 through 96155. • Medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.	**Medicaid/Standard Eligibles, Age 21 and older:** not covered. **Medicaid/Standard Eligibles, Under age 21:** Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall

	consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Agreement. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.
Preventive Care Services	As described in Section 2-3.a.4.
Lab and X-ray Services	**As medically necessary.**
Hospice Care	As medically necessary. Must be provided by a Medicare-certified hospice. If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider.
Dental Services	**Dental Services shall be provided by the Dental Benefits Manager.** **Medicaid/Standard Eligible, Age 21 and older:** Non-covered. **Medicaid/Standard Eligible, Under age 21:** The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21 except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age. Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR when the dental service is covered by the DBM. (See Section 2-3.a.1, and 2-3.c.3)
Vision Services	**Medicaid/Standard Eligible, Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered but shall be subject to the service limitations as described elsewhere in this Agreement. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses will not be covered. One pair of cataract glasses or lenses is covered for adults following cataract

	surgery. **Medicaid/Standard Eligible, Under age 21:** Preventive, diagnostic, and treatments services (including eyeglasses), are covered as medically necessary.
Home Health Care	As medically necessary.
Pharmacy Services	Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below. **Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Medically Needy Adults (Age 21 and older):** 5 Prescriptions per Month of which only 2 may be Brand name **Institutionalized Medicaid Adults (Age 21 and older):** As medically necessary **Standard Eligible, Age 21 and older:** Non-covered **Medicaid/Standard Eligible, Under age 21:** As medically necessary NOTE: Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage. Limits on Pharmacy benefits as well as the effective dates thereof are subject to change based on Waiver and/or Court negotiations. Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics **only (not including services)** shall bill the PBM. Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003. CONTRACTOR RESPONSIBILITIES: The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.

		Services reimbursed by the CONTRACTOR shall not be included in the Pharmacy Benefit Limits as described above. Effective January 1, 2006, provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible shall be administered by Medicare Part D.
Durable Medical Equipment		As medically necessary. Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.
Medical Supplies		As medically necessary. Specified Medical Supplies shall be covered/non-covered in accordance with the TennCare rules and regulations.
Emergency Air And Ground Ambulance Transportation		As medically necessary.
Non-emergency Transportation (including Non-Emergency Ambulance Transportation)		As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation. The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollees age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process. The CONTRACTOR shall provide transportation to and from Dental Services.
Renal Dialysis Services		As medically necessary.
Private Duty		As medically necessary and when prescribed by an attending

Nursing	physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy	**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with EPSDT requirements.
Occupational Therapy	**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with EPSDT requirements.
Physical Therapy	**Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with EPSDT requirements.
Organ and Tissue Transplant And Donor Organ Procurement	**Medicaid/Standard Eligible, Age 21 and older:** All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to: Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with EPSDT requirements. Experimental or investigational transplants are not covered.
Reconstructive Breast Surgery	Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed

		on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Chiropractic Services		**Medicaid/Standard Eligible, Age 21 and older:** Not covered. May be provided by the CONTRACTOR if determined by the CONTRACTOR to be a cost effective alternative. **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with EPSDT requirements.
Sitter		**Medicaid/Standard Eligible, Age 21 and older: NON COVERED** **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.
Convalescent Care		**Medicaid/Standard Eligible, Age 21 and older: NON COVERED** **Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary.

4. Section 2-3.a shall be amended by adding a new Section 2-3.a.2 and renumbering the existing Sections 2-3.a.2 and 3 as 2-3.a.3 and 4 and shall update all references thereto. The new Section 2-3.a.2 shall read as follows:

2-3.a.2. Soft Limits/Service Thresholds for Certain Physical Health Services

TENNCARE has established thresholds that apply to certain covered physical health services for non-institutionalized Medicaid adults. The CONTRACTOR shall track, in a manner prescribed by TENNCARE, and report on accumulated benefit information for each service that has a threshold. Depending on the service, once a member reaches a threshold, the CONTRACTOR shall evaluate and enroll the member in MCO case management or a disease management program as appropriate.

"Institutionalized Medicaid" are not subject to service thresholds and shall be defined as individuals who are receiving (as described in TennCare/Medicaid rules and regulations) long term care institutional services in a nursing home, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through the Home and Community Based Services (HCBS) waiver for these institutional services.

2-3.a.2(a) The service thresholds and the CONTRACTOR's responsibility once a non-institutionalized adult has met the threshold are as follows:

Service	Threshold for Non-Institutionalized Medicaid Eligibles, Age 21 and Older	CONTRACTOR Responsibility Once Member Has Reached Threshold
Inpatient Hospital Services	20 days per SFY	Enroll member in MCO case management or disease management program,

		whichever is more appropriate
Outpatient Hospital Services	8 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	12 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Lab and X-ray Services	10 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate

2-3.a.2(b) The CONTRACTOR shall report, on a quarterly basis as described in Section 2-10.t, the number of members who reach each threshold, were assessed, and/or were enrolled in MCO case management or a disease management program, and the reasons for failure to enroll in MCO case management or disease management.

5. The second paragraph of Section 2-3.b.2(2) shall be amended by deleting the third sentence so that the amended Section 2-3.b.2(2) shall read as follows:

(2) The CONTRACTOR shall demonstrate sufficient access to Centers of Excellence for:

(a) People with AIDS
(b) Children in, or at risk of state custody

To demonstrate sufficient availability and accessibility of Essential Hospital Services and Centers of Excellence, the CONTRACTOR shall complete the "Essential Hospital Services Chart" in Attachment XII, Exhibit D within sixty (60) days of Agreement execution, and by September 1 thereafter of each year for each of the Grand Regions in which it operates for TennCare. At a minimum, in each Grand Region, the CONTRACTOR shall demonstrate a contractual arrangement with at least one (1) Tertiary Care Center for each of the essential hospital services specified above and at least one (1) Center of Excellence for People with AIDs. This minimum requirement is not intended to release the CONTRACTOR to provide or arrange for the provision of any covered service required by its enrollees, whether specified above or not.

6. Section 2-3.j.5 shall be amended by adding a new leading paragraph which shall read as follows:

2-3.j.5. Network Notice Requirements

All member notices required shall be written using the appropriate notice templates provided by TENNCARE and shall include all notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

Failure to comply with notice requirements described herein may result in liquidated damages as described in Section 4-8.b.2 of this Agreement.

7. Section 2-3.j.5(d)(3) shall be amended by deleting and replacing the first sentence of the first paragraph so that the amended Section 2-3.j.5(d)(3) shall read as follows:

2-3.j.5.(d)(3) Other Provider Terminations

The CONTRACTOR shall notify TennCare of any provider termination and submit a copy of one of the actual member notices mailed as well as an electronic listing identifying each member to whom a notice was sent within five (5) business days of the date the member notice was sent as required in Section 2-3.j.5. In addition to the member notice and electronic listing, documentation from the CONTRACTOR's mail room or outside vender indicating the quantity and date member notices were mailed shall be sent to TENNCARE as proof of compliance with the member notification requirements. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

Furthermore, if termination of the CONTRACTOR's provider agreement with any primary care provider or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2-3.b, such termination shall be reported by the CONTRACTOR in writing to the Bureau of TennCare, in the standard format used to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

8. The second paragraph of Section 2-3.k.1 shall be amended by deleting the phrase "and subsequent steps regarding an informal review by TENNCARE" so that the amended Section 2-3.k.1 shall read as follows:

2-3.k.1. Emergency Medical Services obtained from Out of Plan Providers

The CONTRACTOR's plan shall include provisions governing utilization of and payment by the CONTRACTOR for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the CONTRACTOR and shall be consistent with federal requirements regarding post-stabilization services, including but not limited to, 42 CFR Section 438.114(c)(1)(ii)(A). Utilization of and payments to non-contract providers may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care that includes medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TENNCARE rules and regulations for emergency out-of-plan services. Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Agreement. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition as specified in Section 1-3 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and timeframes for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A., Section 56-32-226, including but not limited to MCO reconsideration.

9. Section 2-3.k.6 shall be amended by adding a new paragraph to the end of the existing text so that the amended Section 2-3.k.6 shall read as follows:

2-3.k.6. Credentialing of Non-Contract Providers

Credentialing Standards must apply to all licensed independent practitioners or groups of practitioners who have an independent relationship with the CONTRACTOR. An independent relationship is not synonymous with an independent contract.

The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTOR's network.

10. Section 2-3.s.2 shall be deleted and replaced in its entirety so that the amended Section 2-3.s.2 shall read as follows:

2. **MCO Case Management**

(a) The CONTRACTOR shall maintain an MCO case management program that includes the following components:

(1) A systematic approach to identify eligible members;
(2) Assessment of member needs;
(3) Development of an individualized plan of care;
(4) Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
(5) Monitoring of outcomes.

(b) The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:

(1) Members who have reached the service threshold for inpatient hospital services;
(2) Members who have reached the service threshold for non-inpatient hospital services and could potentially benefit from enrollment in MCO case management;

(3) Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions;
(4) Members who meet the requirements at 2-3.s.5(a) regarding excessive and/or inappropriate Emergency Department Utilization; and
(5) Children with special health care needs unless already enrolled in an appropriate disease management program.

(c) Members who have reached the service threshold for inpatient hospital services shall be enrolled in either MCO case management or a disease management program.

(d) Eligible members must be offered MCO case management services. However, member participation shall be voluntary.

(e) The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP when a member has been assigned to the MCO case management program.

(f) The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member has reached a service threshold.

11. Section 2-3.s.5 shall be amended by adding additional text to the end of the existing text so that the amended Section 2-3.s.5 shall read as follows:

5. Excessive and/or Inappropriate Emergency Department (ED) Utilization. The CONTRACTOR shall utilize the following guidelines in identifying and managing care for enrollees who are determined to have excessive and/or inappropriate ED utilization.

(a) Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify enrollees with utilization exceeding a threshold defined by TENNCARE in the preceding six (6) month period. In January, review ED utilization during the preceding April through September. In July review ED utilization during the preceding October through March.
(b) Enroll in active case management – (Enrollees who exceed a specified number, to be defined by TENNCARE, of ED visits in the previous six (6) month period)
(c) Make contact with enrollee and primary care provider
(d) Review encounter data
(e) Assess most likely cause of problem (e.g., drug seeking behavior, primary care/access problem, poorly controlled disease state, etc.)
(f) Develop a case management plan based on results of the assessment. Sample plans based on potential assessment results follow:
(1) Drug seeking behavior
i. Interact with TennCare Pharmacy Division regarding possibility of pharmacy lock-in and/or controlled substance prior authorization requirement
ii. Contact all providers regarding concern that patient may be abusing prescription medications
iii. Make appropriate referrals (e.g., OIG, Pain clinic, Substance abuse treatment program, etc.)

iv. Consider primary care provider lock-in (i.e. patient must have PCP approval before he/she can access other providers)

(2) Primary Care /Access Problem
- i. Change PCP and/or address problem with current PCP
- ii. Provide enrollee education regarding appropriate use of PCP and ED
- iii. Provide access to a 1-800 customer service line for assistance identifying and selecting a PCP and to the extent necessary, assistance scheduling an appointment with PCP

(3) Poorly controlled disease
- i. Enroll in disease management
- ii. Refer to specialist for management – advise PCP
- iii. Provide access to 1-800 24/7 nurse answered line capable of providing health information/education to patients; healthcare counseling/telephone triage to assess health status to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings.

(g) Any blanket policy to deny payment for specified "non-emergency" services in the ED based on diagnoses must be accompanied by the following guidelines.
- (1) Clear communication to all hospitals/EDs regarding the diagnoses that are and are not considered emergencies;
- (2) A process whereby the hospital could demonstrate that a condition on the list did, in fact, represent an emergency;
- (3) Clear communication to all hospitals/EDs regarding the mechanism to bill for the EMTALA required screen associated with any non-emergency diagnoses;
- (4) Payment for the EMTALA screens associated with any non-emergency diagnosis, and
- (5) A specific process that the MCO shares with all hospitals/EDs by which the ED can contact the MCO 24/7 to refer an enrollee with one of the non-emergency diagnoses to the MCO for assistance in arranging for care in an alternative setting, when such assistance is requested by the member.

(h) If the CONTRACTOR requires EDs to refer members with non-urgent/emergent conditions to alternative settings for treatment, the MCO must have a specific process in place whereby the ED can contact the MCO 24/7 to assist enrollees with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting.

If the CONTRACTOR chooses to implement a blanket policy as identified in subsection (g) above, failure to comply with the ED guidelines as described therein may result in liquidated damages as described in Section 4-8.b.2 of this Agreement.

12. Section 2-3.s.6 shall be deleted in its entirety and replaced by a new Section 2-3.s.6 which shall read as follows:

6. Disease Management. Each MCO is required to establish and operate (either directly or via a subcontract with a disease management vendor) a minimum of four disease management (DM)

programs designed to address maternity care management, comprehensive diabetes management, management of congestive heart failure and management of asthma.

Each DM program must utilize evidence-based best practice guidelines and patient empowerment strategies to support the practitioner-patient relationship and the plan of care. The programs must emphasize prevention of exacerbation and complications as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

(a) DM Program Policies and Procedures

The CONTRACTOR shall develop and maintain DM program policies and procedures. These policies and procedures must include, for each of the conditions listed above, the following:

(1) Definition of the target population;
(2) Member identification strategies;
(3) Program content including, but not limited to:
    (a) Evidence-based best practice guidelines upon which the program is based;
    (b) Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;
    (c) Methods for informing and educating members;
    (d) Methods for informing and educating providers; and
(4) Program evaluation.

As part of its DM program policies and procedures, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

(b) **Member Identification Strategies**

The MCO must have a systematic method of identifying and enrolling eligible members in each DM program. This shall include but not be limited to:

(1) Members who have reached the service threshold for inpatient hospital services (see Section 2-3.a.2).
(2) Members who have reached the service threshold for other non-inpatient hospital services (see Section 2-3.a.2) and could potentially benefit from enrollment in a disease management program.
(3) Members who meet the requirements at 2-3.s.5(f)(3) regarding excessive and/or inappropriate Emergency Department Utilization who could potentially benefit from enrollment in a disease management program.
(4) Members who have reached the service threshold for inpatient hospital services shall be enrolled in either a disease management program or MCO case management, whichever the CONTRACTOR determines is more appropriate.

The MCO must operate each program using an "opt out" methodology, meaning that services will be provided to eligible members unless they specifically ask to be excluded. The Bureau may elect to mandate the eligibility criteria the MCO must use if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the criteria in use are overly restrictive.

(c) Program Content

The MCO must adopt clinical practice guidelines that serve as the basis for each DM program. The guidelines must be evidence-based and formally adopted by the QI or other clinical committee. The guidelines must be distributed to practitioners who are likely to use them and must be made available to the Bureau upon request. Upon enrollment in the DM program, the MCO must provide information to the member and practitioner regarding how to use the services and specific information to the practitioner concerning how the program works with the practitioner's patients. MCOs must provide primary care providers with a list of their patients enrolled in each program upon initial enrollment and at least annually thereafter.

Each DM program must be based on a treatment plan that serves as the outline for all of the activities/interventions in the program. At a minimum the activities/interventions associated with the treatment plan must address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues. The Bureau may elect to mandate an intervention strategy the MCO must employ if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the interventions are suboptimal.

(d) Stratification

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information. The DM programs shall tailor the program content, education activities, and benchmarks and goals for each risk level.

(e) CONTRACTOR's Program Description

Annually, on July 1, the CONTRACTOR shall submit a description of it's Disease Management Program that shall include the following:

1. Definition of the target population for each program and the method used to identify and enroll members; and
2. Written description of the stratification levels for each of the four (4) programs, including member criteria and associated interventions.

(f) **Informing and Educating Members**

The DM programs shall educate members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

(1) Are proactive and effective partners in their care;
(2) Understand the appropriate use of resources needed for their care;
(3) Identify precipitating factors and appropriate responses before they require more acute intervention; and

(4) Are compliant and cooperative with the recommended treatment plan.

(g) **Informing and Educating Providers**

As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

(h) Program Evaluation

The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include the following information. This information shall be reported to TENNCARE annually on July 1st in accordance with Section 2-10.m.7.

1. The total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required DM programs;
2. The active participation rate (as defined by NCQA) for each of the required DM programs, including the numerator and denominator used in calculating the rate
3. The number of individuals participating in each level or stratification of each of the DM programs;
4. Performance measured against at least two important aspects of the clinical practice guidelines associated with each DM program;
5. The rate of emergency department utilization and inpatient hospitalization for members with diabetes, asthma and congestive heart failure (rate calculations must be shown);
6. Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the Maternity Management Program;
7. HEDIS measures related to any of the four DM projects; and
8. Any other performance measure associated with any of the four DM programs that the MCO has chosen to track.

13. The second paragraph of Section 2-3.u shall be amended by adding a new third sentence so that the first two paragraphs of Section 2-3.u shall read as follows:

2-3.u. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, as well as outreach and education. The CONTRACTOR must assure the availability and accessibility of required health care resources and help enrollees and their parents or guardians use these resources effectively. The State EPSDT program shall be referred to as "TENNderCare". The CONTRACTOR shall use

"TENNderCare" in describing or naming an EPSDT program or services. This shall include, but not be limited to, all policies, procedures and/or marketing material, regardless of the format or media. No other names or labels shall be utilized. CONTRACTORS may, however, use existing EPSDT materials through December 31, 2004. Any new or reprinted EPSDT materials shall use TENNderCare as of July 1, 2004.

The CONTRACTOR shall provide EPSDT services to enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. EPSDT Services means early and periodic screening, diagnosis and treatment of enrollees under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan. The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit). The CONTRACTOR shall be responsible for the provision of all related services except for behavioral health services that are carved out as a separate arrangement from this Agreement as well as Pharmacy and Dental services at such time as they are removed from the responsibilities described in this Agreement. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

14. Section 2-3.u.2 shall be amended by deleting and replacing the last paragraph so that the amended Section 2-3.u.2 shall read as follows:

2-3.u.2 42 CFR 441.56(b) defines "screening" as "periodic comprehensive child health assessments" meaning "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, screenings must include, but are not limited to:

(a) Comprehensive health and developmental history;
(b) Comprehensive unclothed physical examination;
(c) Appropriate Immunizations;
(d) Appropriate vision and hearing testing;
(e) Appropriate laboratory tests; and
(f) Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate; and
(g) Health Education.

At a minimum, these screening services shall include periodic and interperiodic screens and must be provided in accordance with "reasonable standards of medical and dental practice" as determined by the State. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Pursuant to Section 2-3.a.3, "screens shall be in accordance with the periodicity schedule set forth in the latest 'American Academy of Pediatrics

Recommendations For Preventive Pediatric Health Care' and all components of the screens must be consistent with the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and the American Academy of Pediatric Dentistry (AAPD) guidelines. The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all medically necessary TENNderCare covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the CONTRACTOR or by an in-network provider.

15. Section 2-5.b.1(t) shall be deleted in its entirety and replaced by a new Section 2-5.b.1(t) which shall read as follows:

(t) Shall include member services toll free telephone numbers; including the TENNCARE Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line with a statement that the enrollee may contact the plan or TENNCARE regarding questions about TennCare as well as the service/information that may be obtained from each line. The TennCare hotline number is 1-866-311-4287;

16. Section 2-5.b.2 shall be amended by adding a new (e) and renumbering the existing (e) as (f) so that the new Section 2-5.b.2(e) shall read as follows:

(e) member services toll free telephone numbers; including the TennCare Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line as well as the service/information that may be obtained from each line; and

17. Section 2-5.b.4 shall be amended by adding the phrase "or prior to enrollee's beginning effective date" to the end of the first sentence so that the amended Section 2-5.b.4 shall read as follows:

2-5.b.4. Provider Directory

The CONTRACTOR shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan or prior to enrollee's beginning effective date. The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. Provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network PCPs and specialists, hospital listings including locations of emergency settings and post stabilization services, identification of providers accepting new patients and whether or not a provider performs EPSDT screens. Enrollee provider directories, and any revisions thereto, shall be submitted to TENNCARE for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TENNCARE and be produced using the same extract process as the actual enrollee provider directory. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider

directory has been previously mailed to enrollees in the existing case. These updates shall be maintained in accordance with Section 2-2.n of this Agreement.

18. Section 2-8 shall be deleted and replaced in its entirety so that the new Section 2-8 shall read as follows:

2-8. Complaints and Appeals

Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider with the member's written consent. Complaint shall mean a member's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2-5.b.1. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2-9.j., to the review of member complaints and appeals that have been received.

The CONTRACTOR shall ensure that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2-8.a. Appeals

The CONTRACTOR's appeal process shall include, at a minimum, the following:

2-8.a.1. The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.

2-8.a.2. The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.

2-8.a.3. The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal.

2-8.a.4. The CONTRACTOR shall identify the appropriate individual or body within the plan having decision-making authority as part of the appeal procedure.

2-8.a.5. The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.

2-8.a.6. Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).

2-8.a.7. The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.

2-8.a.8. At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the Member and TENNCARE.

2-8.a.9. The Contractor shall require providers to display notices of member's right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The Contractor shall ensure that providers have correct and adequate supply of public notices.

2-8.a.10 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.

2-8.a.11. The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.

2-8.a.12. TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.

2-8.a.13 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals(described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.

2-8.a.14. The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.

2-8.a.15. The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2-3.d.5.

2-8.a.16. The CONTRACOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to

take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)

2-8.a.17. Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and co-payment responsibilities shall be directed to the Department of Human Services.

If it is determined by TENNCARE that violations regarding the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require that the CONTRACTOR submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 4-8. of this Agreement.

19. Section 2-9.c shall be amended by adding a new 8 and renumbering the existing 2-9.c.8 through 2.9.c.13 accordingly, including all references thereto, so that the new Section 2-9.c.8 shall read as follows:

8. The CONTRACTOR shall maintain a 1-800 Nurse Triage line that shall be available to members 24 hours a day, seven days a week. The 24/7 Nurse Triage line service shall provide health information/education to patients; healthcare counseling/telephone triage to assess health status in order to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings. The CONTRACTOR shall include information on the Nurse Triage line, including the telephone number and the services/information available by calling the line, in the member handbook and in quarterly member newsletters.

20. Section 2-9.j.6 shall be amended by adding a new second paragraph so that the amended Section 2-9.j.6 shall read as follows:

2-9.j.6. Credentialing and Recredentialing

The CONTRACTOR utilizes current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentailing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action. The CONTRACTOR shall further adhere to the credentialing requirements described in Section 2-3.k.6 of this Agreement regarding non-contract providers.

The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application. Completely process shall mean that the CONTRACTOR shall review and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTOR's network.

21. Section 2-9.k. shall be amended by adding a new 7 so that the new Section 2-9.k.7 shall read as follows:

2-9.k.7. Subrogation (Casualty) Recovery

The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation related claims. This editing should identify claims with a diagnosis of 800.00 thru 999.99 (excluding 994.6) or a claim submitted with an accident trauma indicator of 'Y'. TENNCARE approved questionnaires or other type TENNCARE approved forms shall be used to

gather data and information pertinent to potential subrogation cases. TENNCARE shall determine a threshold amount for which a subrogation case should be pursued.

22. Section 2-10.b.1 shall be amended by adding new text to the end of the existing text so that the amended Section 2-10.b.1 shall read as follows:

2-10.b.1. Enrollee Information, Weekly Reporting

The CONTRACTOR shall submit weekly reports in an electronic format, unless otherwise specified or approved by TENNCARE in writing, which shall serve as the source of information for a change in the enrollee's TennCare information. Such information shall serve as the source of information for a change in the enrollee's address and/or selection of MCO plan. This report shall include enrollees who move outside the CONTRACTOR's service area as well as enrollees who move to a new address within the CONTRACTOR's service area. The CONTRACTOR agrees to work with the State to devise a methodology to use returned mail to identify enrollees who have moved and whose whereabouts is unknown.

Within ninety (90) days of the time that TENNCARE develops and describes to the CONTRACTOR the new reporting procedures, the CONTRACTOR shall also be required to include in the report, described above, any information which is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability including limited coverage and exclusionary riders to policies, whether or not the enrollee is incarcerated, or resides outside the State of Tennessee. The minimum data elements that will be required for this report can be found in Attachment XII, Exhibit A of this Agreement.

The CONTRACTOR shall gather, store and update a minimum of the following health insurance information:

- Recipient SSN
- Type of Coverage (Inpatient, outpatient, pharmacy, dental, vision, etc.)
- Policyholder name
- Policyholder SSN, if available
- Policyholder's relationship to the recipient
- TennCare Carrier Number, Carrier name and address, if available
- Policy number
- Begin and end dates of policy.

Health insurance data provided by the CONTRACTOR that does not include the above required fields will be returned to the CONTRACTOR.

23. Section 2-10.c.1 shall be deleted and replaced in its entirety so that the amended 2-10.c.1 shall read as follows:

2-10.c.1. Monthly Provider Enrollment File

The CONTRACTOR shall furnish to TENNCARE at the beginning of the Agreement period an electronic report in the format specified by TENNCARE listing all providers enrolled in the

TennCare plan, including but not limited to, physicians, dentists, hospitals, home health agencies, pharmacies, medical vendors, ambulance, etc. This listing shall include regularly enrolled providers, specialty or referral providers and any other provider, which may be enrolled for purposes of payment for services provided out-of-plan. The minimum data elements required for all provider listings required in this Section may be found in Attachment XII, Exhibit C of this Agreement. The CONTRACTOR shall be required to inquire as to the provider's race and/or national origin and shall report to TENNCARE the information, if any, furnished by the provider in response to such an inquiry. The CONTRACTOR shall be prohibited from requiring the provider to declare race and/or national origin and shall not utilize information regarding race or national origin obtained pursuant to such request as a basis for decisions regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

Thereafter, a complete electronic provider replacement file (full file refresh) shall be submitted on a monthly basis by the 5th of each month. This information shall be used to determine CONTRACTOR compliance with network adequacy standards and shall be used in conjunction with encounter data.

Each provider shall be identified by a Tennessee Medicaid I.D. number (i.e., each servicing provider in a group or clinic practice must be identified by a separate provider number). This unique identifier shall appear on all encounter data transmittals.

Within ten (10) working days of a request by TENNCARE, the CONTRACTOR shall provide an unduplicated listing of all contracting providers, in a format designated by TENNCARE.

Failure to report the provider information, as specified above, shall result in the application of liquidated damages as described in Section 4-8 of this Agreement.

24. Section 2-10.e.3 shall be deleted in its entirety and replaced by a new Section 2-10.e.3 which shall read as follows:

2-10.e.3. Reporting Provider Payment Issues

(a) If the CONTRACTOR does not automatically credit TENNCARE for receivables within ninety (90) calendar days, the CONTRACTOR shall determine the extent of the collection effort required based on the table below. This table identifies the minimum collection threshold for cumulative receivable balances. All collection efforts shall be clearly documented.

Receivable Balance	Collection Attempts 45 Day	90 Day	Forwarded to Collections
< $10	None Required		
$10 - $49.99	✓		
$50 - $99.99	✓	✓	
$100 - Over	✓	✓	✓
Responsibility	MCC		TENNCARE

The first notice shall occur by day forty-five (45) and may be in the form of notice in a remittance advice or a demand memo; however, the ninety (90) day notice must be made using a demand memo. Each of these notices shall be sent within five (5) business days of becoming due.

Additional collection attempts by the CONTRACTOR are not necessary if a collection notice is returned because the provider has gone out-of-business or has declared bankruptcy for the period the receivable was established. This circumstance must be reported in the "Uncollectible Accounts Report" as described below.

Failure to send the notices as scheduled may result in liquidated damages as described in Section 4-8 of this Agreement.

(b) If the CONTRACTOR does not automatically credit TENNCARE for aged accounts within sixty (60) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an "Aged Accounts Receivable report". The effective date of this report shall be the last Friday of the previous month. The report shall have an easily identifiable date, contain a total report balance, and provide <30, 30, 60, 90, and >120 calendar day balances. Although only totals are required, the CONTRACTOR may report aging balances at the account level. If the CONTRACTOR is not reporting at the account level, the CONTRACTOR shall have the capability to identify the detail that makes up a total if necessary.

(c) If the CONTRACTOR does not automatically credit TENNCARE for uncollectible accounts within ninety (90) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an "Uncollectible Accounts Report", in a format described by TENNCARE, for accounts meeting the following criteria:

(1) the account proves to be uncollectible after 120 calendar days, or
(2) the provider account owner has gone out-of-business, or
(3) the provider account owner has declared bankruptcy.

In addition to the "Uncollectible Accounts Report" report, the CONTRACTOR shall submit scanned copies of returned envelopes or legal documents referencing providers that have gone out-of-business and/or declared bankruptcy.

(d) The Contractor shall provide TENNCARE a report, in a format described by TENNCARE, detailing all checks remitted to providers, enrollees or vendors on behalf of the State which remain outstanding (which have not been cashed) greater than one hundred eighty (180) calendar days. Reports are due monthly within fifteen (15) business days after the end of the month.

Failure to report outstanding checks to TENNCARE as described above may result in liquidated damages as described in Section 4-8 of this Agreement.

25. Section 2-10.m.3 shall be amended by adding "or prior to enrollee's beginning effective date" before "on a quarterly basis" in the first sentence so that the amended Section 2-10.m.3 shall read as follows:

2-10.m.3. PCP Assignment

The CONTRACTOR shall submit a report to TENNCARE including the total number of enrollees and percentage of total enrollees in each Grand Region that have not been assigned to a primary care provider (PCP) within thirty (30) days of enrollment or prior to enrollee's beginning effective date, on a quarterly basis. This report shall be submitted electronically.

26. Section 2-10.m.7 shall be deleted and replaced in its entirety so that the amended Section 2-10.m.7 shall read as follows:

2-10.m.7. Disease Management Reports

(a) The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program as described in Section 2-3.s.6, a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall be submitted in a format prescribed by TENNCARE.

(b) Annually on July 1st, the CONTRACTOR shall submit a *Disease Management Report* that includes, the information specified in 2-3.s.6 (e) and (h). The report shall be submitted in a format prescribed by TENNCARE.

27. Section 2-10.o shall be deleted and replaced in its entirety so that the amended Section 2-10.o shall read as follows:

2-10.o. Cost and Utilization Reports

The CONTRACTOR shall report Cost and Utilization information by TennCare enrollee eligibility category as described in Attachment XII, Exhibits L.1 through L.5 and as required below. CONTRACTOR shall submit a written explanation for how service data will be mapped to the categories identified in said Exhibits by August 1, 2002. These reports shall be maintained in an Excel spreadsheet format and shall be sent via e-mail to TENNCARE on a quarterly basis, based on incurred date, with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting.

1. Attachment XII, Exhibits L.1 through L.5 shall be submitted for each quarter on a "Cumulative Year to Date" basis.

2. Attachment XII, Exhibits L.1 through L.5 shall be submitted for each quarter on a "Rolling Twelve (12) Month" basis. Please note that the aggregated payment information of these reports for certain reporting periods should be reasonably tied the CONTRACTOR's MSBT reports, and invoices/encounters submitted by the CONTRACTOR for the comparable periods.

28. Section 2-10 shall be amended by adding a new Section 2-10.t which shall read as follows:

2-10.t. Benefits/Service Requirements and Limits Reports

The CONTRACTOR shall submit a quarterly *Service Threshold Report* in the format prescribed by TENNCARE. At minimum, the report shall include: the number of members who reached each service threshold; confirmation that all members who reached the service threshold for mandatory enrollment in MCO case management or a disease management program were enrolled; the number of members who reached the service threshold for evaluation of appropriateness for enrollment in MCO case management or disease management who were evaluated for enrollment; the number of those members evaluated who were enrolled in MCO case management or disease management (by program); and the number of those members who were evaluated but not enrolled in MCO case management or disease management by reason.

29. Section 2-18.ee shall be amended by deleting "non-emergency" so that the amended Section 2-18.ee shall read as follows:

2-18.ee. Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the MCO as provided at T.C.A. 56-32-226(b).

2-18. ff. Include a conflict of interest clause as stated in subsections (a) and (c) of Section 4-7, Gratuities clause as stated in 4-11 and Lobbying clause as stated in 4-12 of this Agreement between the CONTRACTOR and TENNCARE;

30. Section 2-24.i shall be amended by adding a new sentence to the end so that the amended Section 2-24.i shall read as follows:

2-24.i. On an annual basis, the CONTRACTOR's Title VI Compliance Plan and Assurance of Non-discrimination. The signature date of the CONTRACTOR's Title VI Compliance Plan is to coordinate with the signature date of the CONTRACTOR's Assurance of Non-discrimination Compliance.

31. Section 3-10.i shall be deleted in its entirety and replaced by a new 3-10.i which shall read as follows:

3-10.i. Shared Risk Terms and Conditions

Effective July 1, 2005, the terms of the CONTRACTOR's shared risk responsibility shall be described below. The CONTRACTOR will be paid an administrative fee to administer the TennCare MCO benefits in accordance with the Amended and Restated CRA, as amended.

To balance the Shared Risk framework, TennCare has established two components to the Model: Risk based (downside potential) and Bonus based (upside potential). These components shall encompass the Medical Services Budget Targets (MSBT), Administrative Fee paid to the MCO, and five (5) TennCare priority initiatives: Pharmacy, NCQA, and EPSDT, Emergency Room Visits per 1000 and Inpatient Admissions per 1000. The Medical Services Budget Targets (medical costs) will be the key component for the shared risk model. For the period July 1, 2005 through June 30, 2006, where appropriate, benchmarks will be based on each MCOs individual experience as described below. Some of the benchmarks are derived from the CONTRACTOR's self reported information; however, to the extent that TENNCARE produces the benchmark, TENNCARE shall provide the CONTRACTOR with the individual benchmarks for those initiatives by June 15, 2005. Effective July 1, 2006, all benchmarks, with the exception of the EPSDT screening rate, will be based on performance measures established by TENNCARE using claims data submitted by the CONTRACTOR and in addition to the benchmarks described above shall include Inpatient Days per 1000.

As relates to the Medical Services Budget Target, Non-Emergency ER Visits per 1000, EPSDT Compliance, Inpatient Admissions per 1000, Inpatient Days per 1000, and Pharmacy Generic Usage, the parties hereby agree that the aggregate base line acuity for the population administered by the CONTRACTOR shall be based on a methodology that shall be agreed upon by both parties.

The Parties further agree that the ability of the CONTRACTOR to achieve these initiatives is directly and materially related to said base line acuity of the aggregate population. As an integral part of evaluating the CONTRACTOR's performance in achieving the goals set forth above, the CONTRACTOR and TennCare shall perform a quarterly follow-up acuity review of the aggregate population. The CONTRACTOR and TennCare shall perform a reconciliation of aggregate acuity of the CONTRACTOR's assigned population and show compliance with the Shared Risk Initiatives adjusting for changes in acuity population and supply said adjustment data to TENNCARE for review and approval on a quarterly basis. The adjusted base line numbers for acuity shall serve as the standard for the determination as to whether the CONTRACTOR achieved the Shared Risk Initiatives.

In addition, the Parties hereby agree that the determination of achieving compliance with the above Shared Risk Initiatives shall be consistent with the obligations of this Agreement as they are performed and interpreted as of July 1, 2006. As such, services provided as a result of compliance with an instruction or mandate from the TennCare Bureau that is in conflict with, or in excess of, those obligations pursuant to this Agreement as of July 1, 2006 shall be taken into account and not counted against the Contractor in determining the achievement of the Shared Risk Initiatives.

3-10.i.1. Administrative Fee

The CONTRACTOR shall be paid an administrative fee based on the number of enrollees assigned to the plan as described in Attachment X.

3-10.i.2 Medical Services Budget Target

The CONTRACTOR shall submit a Medical Services Monitoring Report monthly with cumulative year to date calculation using the instructions in Attachment XII, Exhibit J in accordance with Section 2-10.j of this Agreement. From this report, TennCare will compute a quarterly Medical Services Budget Target. This will be established by computing the percent change for each quarter two years historically. A percent change will be computed for each quarter compared to the prior year quarter. This trend will be applied to the per member costs for previous year quarter to establish the Medical Services Budget Target for future quarters.

The MSBT will be evaluated in terms of the prior year quarter for the same timeframe (i.e. 3rd Qtr 2005 will be compared to 3rd Qtr 2004). The data from the Medical Services Budget Target quarterly update will be used to establish the quarterly PMPMs. Effective July 1, 2006, the MSBT Benchmark shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR prior to July 1, 2006.

3-10.i.3. Risk Component

The Shared Risk Model will require that a percent of the overall budget that is directly related to patient care and overall medical costs be placed at risk. The Model will set ten percent (10%) of the administrative fee (or budget) at risk; the ten percent (10%) will either be earned or lost based on Plan performance.

The Shared Risk Initiatives are listed below along with its associated risk contribution.

Shared Risk Initiative	Contribution to Risk
Medical Services Budget Target	2.0%

Usage of Generic Drugs	2.0%
Completion of Major Milestone for NCQA	1.0%
EPSDT Compliance	2.0%
Non-Emergency ER Visits per 1000	1.0%
Inpatient Admissions per 1000	1.0%
Inpatient Days per 1000	1.0%

3-10.i.3(a) ***Medical Services Budget Target Initiative***

At the end of the evaluation period associated with the MSBT, if the actual medical costs + IBNR is less than or equal to 100% of the MSBT, the CONTRACTOR shall retain 100% of the administrative fee associated with the MSBT. If the actual medical costs + IBNR is more than 100% of the MSBT, the CONTRACTOR's administrative fee associated with the MSBT shall be adjusted in accordance with the chart below. The Table below illustrates the risk corridors for the Medical Services Budget target:

Percent of MSBT	**Administrative Fee Adjustment**
≤ 102%	All admin assoc with MSBT at risk portion and potential bonus
> 102% and ≤ 105%	-25% of admin assoc MSBT risk portion
> 105% and ≤ 110%	-50% of admin assoc MSBT risk portion
> 110% and ≤ 115%	-75% of admin assoc MSBT risk portion
> 115% and greater	-100% of admin assoc MSBT risk portion

Evaluation Period: Quarterly with a 90 day lag
At Risk Portion: 2% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

3-10.i.3(b) ***Pharmacy Generic Use:***

The Bureau will establish current generic trends for each MCO based on utilization data reported by the Pharmacy Benefits Manager (PBM).
This initiative targets the pharmacy generic use rates for the MCOs. Each MCO will have a target established for their enrollee population based on the MCOs individual experience. Administrative fees will be adjusted based on deviations from the MCO generic use benchmark as listed below.

Percent of Generic Usage Target	**Administrative Fee Adjustment**
≥ 95%	All admin assoc with Generic Drug Usage at risk portion and potential bonus
< 95% and ≥ 90%	-25% of admin assoc Generic Drug Usage risk portion
< 90% and ≥ 85%	-50% of admin assoc Generic Drug Usage risk portion
< 85% and ≥ 80%	-75% of admin assoc Generic Drug Usage risk portion
< 80%	-100% of admin assoc Generic Drug Usage risk portion

Evaluation Period: Quarterly
At Risk Portion: 2.0% of Administrative Fee (Budget)
Implementation Date: October 1, 2005 (after the TennCare Reform change in enrollment)

3-10.i.3(c) ***Completion of Major Milestones for NCQA:***

A major initiative for TennCare is the accreditation of all MCOs by NCQA. The Bureau has established an 18 month timeframe for all MCOs to be accredited. There are critical milestones that must be adhered to by the MCOs. Listed below are the major milestones with the associated due date as referenced in the Amended and Restated Contractor Risk Agreement.

For dates of service July 1, 2005 through June 30, 2006, the NCQA benchmarks are as follows:

1. Utilize the NCQA approved Quality Improvement Activity Form to submit baseline data, barrier analysis, and planned interventions for three (3) Clinical and two (2) Service Improvement Studies selected by MCO. **Due Date: September 15, 2005.**

2. NCQA Accreditation Survey Application Submitted and Pre-Survey Fee Paid. **Due Date: November 15, 2005.**

3. Copy of Signed Contract with NCQA Approved Vendor to Perform 2006 CAHPS Survey to TennCare Chief Medical Officer. **Due Date: November 15, 2005.**

4. Copy of Signed Contract with NCQA Approved Vendor to Perform 2006 HEDIS Audit to TennCare Chief Medical Officer. **Due Date: November 15, 2005.**

5. Copy of Signed Contract with NCQA Survey Contract to TennCare Chief Medical Officer. **Due Date: December 15, 2005.**

A **0.4%** reduction in admin fee associated with NCQA will be assessed for each milestone not met.

Evaluation Period: By Specified Due Date
At Risk Portion: 2.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

Effective July 1, 2006 the NCQA benchmarks are as follows:

1. Submit ISS to NCQA. **Due Date: September 18, 2006.**

2. NCQA Survey Completed and copy of NCQA Final Report to TennCare **Due Date: December 31, 2006**

A **0.5%** reduction in admin fee associated with NCQA will be assessed for each milestone not met.

Evaluation Period: By Specified Due Date
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2006

3-10.i.3(d) ***Increase EPSDT Compliance***

The goal is to insure that all children under the age of twenty-one (21) are receiving screenings consistent with the periodicity schedule referenced in the Amended and restated Contractor Risk Agreement. Section 3-10.h.3(a) currently provides opportunity for the CONTRACTOR to receive a bonus for increasing EPSDT screening rates for the time period October 1, 2004 through September 30, 2005 only. The TennCare Program goal for EPSDT compliance is 80% and the CONTRACTOR shall make every effort to attain said goal. Effective July 1, 2006 a percentage of the administrative fee shall be placed at risk based on the CONTRACTOR's compliance with an EPSDT screening rate of 80%.

TENNCARE shall use the CMS 416 format in order to measure the CONTRACTOR's progress on a quarterly basis. In order to encourage continued progress, the administrative rate shall be reconciled in accordance with the following:

Percentage of EPSDT Compliance Benchmark	**Administrative Fee Adjustment**
≥ 100%	All admin assoc with EPSDT Screening rate compliance risk portion and potential bonus
≥ 95% and < 100%	-25% of admin assoc EPSDT Screening rate compliance risk portion
≥ 90% and < 95%	-50% of admin assoc EPSDT Screening rate compliance risk portion
≥ 85% and < 90%	-75% of admin assoc EPSDT Screening rate compliance risk portion
< 85% and lower	-100% of admin assoc EPSDT Screening rate compliance risk portion

Evaluation Period: Quarterly with a 90 day lag for a rolling twelve (12) month period
At Risk Portion: 2.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

3-10.i.3(e) ***Non-Emergency ER Visits per 1000:***

TennCare will establish benchmarks for Non Emergency ER visits. Each MCO Non Emergency ER Visits/1000 benchmark will be derived from the Plan Cost and Utilization reports. TENNCARE shall provide the CONTRACTOR with a document which shall define Non-Emergency ER Visits for the purposes of reporting and documenting the achievement of this benchmark. Effective July 1, 2006, the ER Visits/1000 benchmark shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR prior to July 1, 2006.

Percentage of ER Visists/1000 (NE) Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with ER Visits per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc ER Visits per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc ER Visits per 1000 risk portion
> 115% and ≤ 120%	-75% of admin assoc ER Visits per 1000 risk portion

> 120% and greater	-100% of admin assoc ER Visits per 1000 risk portion

Evaluation Period: Quarterly with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

3-10.i.3(f) ***Inpatient Admissions per 1000:***

TennCare will establish benchmarks for Inpatient Admits/1000. Effective July 1, 2005 through June 30, 2006, each MCO Inpatient Admits/1000 benchmark will be derived from the Plan Cost and utilization reports. Effective July 1, 2006, the Inpatient Admits per 1000 benchmark shall be established by TENNCARE based on the CONTRACTOR's claims data and shall be provided to the CONTRACTOR prior to July 1, 2006.

Percentage of Inpatient Admissions/1000 Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with Inpatient Admits per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc Inpatient Admits per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc Inpatient Admits per 1000 risk portion
> 115% and ≤ 120%	-75% of admin assoc Inpatient Admits per 1000 risk portion
> 120% and greater	-100% of admin assoc Inpatient Admits per 1000 risk portion

Evaluation Period: Quarterly with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2005

3-10.i.3(g) ***Inpatient Days Per 1000***

TennCare will establish benchmarks for Inpatient Days per 1000 based on the CONTRACTOR's claims data and shall provide the benchmark to the CONTRACTOR prior to July 1, 2006.

Percentage of Inpatient Days per 1000 Benchmark	**Administrative Fee Adjustment**
≤ 105%	All admin assoc with Inpatient Days per 1000 at risk portion and potential bonus
> 105% and ≤ 110%	-25% of admin assoc Inpatient Days per 1000 risk portion
> 110% and ≤ 115%	-50% of admin assoc Inpatient Days per 1000 risk portion
> 115% and ≤ 120%	-75% of admin assoc Inpatient Days per 1000 risk portion
> 120% and greater	-100% of admin assoc Inpatient Days per 1000 risk portion

Evaluation Period: Quarterly with a 90 day lag
At Risk Portion: 1.0% of Administrative Fee (Budget)
Implementation Date: July 1, 2006

3-10.i.4. Performance Bonuses

TennCare will establish a bonus pool for each Risk Initiative. The bonus pool will represent fifteen percent (15%) of the administrative fee for the CONTRACTOR as described in Attachment X. The following Initiatives will be included in the Bonus Pool: Medical Services Budget Target, Generic Usage, EPSDT Compliance, ER Visits/1000 (NE), and Inpatient Admits/1000. Effective July 1, 2006, Inpatient Days per 1000 shall be one of the initiatives included in the Bonus Pool. The following table identifies the weighting for each Initiative:

Shared Risk Initiative	Contribution to Bonus
Medical Services Budget Target	5.0%
Usage of Generic Drugs	2.0%
EPSDT Compliance	2.0%
ER Visits/1000 (NE)	2.0%
Inpatient Admits/1000	2.0%
Inpatient Days/1000	2.0%

The distribution of bonuses are tied to the assumptions listed in the table below and are computed after they are weighted by the contribution of the Initiatives to the Bonus Pool. The effective dates for each bonus pool initiative are as follows: MSBT – July 1, 2005; Generic Drugs Rate – October 1, 2005; EPSDT Compliance – July 1, 2005; ER.Visits/1000 (NE) – July 1, 2005; Inpatient Admits/1000 – July 1, 2005; and Inpatient Days/1000 – July 1, 2006.

Additional Bonus Points

Performance – Percent Exceeding Target	Usage of Generic Drugs Target	EPSDT Compliance Target
> 100% and ≤ 105%	25%	25%
> 105% and ≤ 110%	50%	50%
> 110% and ≤ 120%	75%	75%
> 120% and over	100%	100%

Performance – Percent Improving Target	Medical Services Budget Target
< 98% and ≥ 95%	25%
< 95% and ≥ 90%	50%
< 90% and ≥ 85%	75%
< 85%	100%

Performance – Percent Improving Target	ER Visits/1000 (NE) Target	Inpatient Admits/1000 Target	Inpatient Days/1000 Target
< 100% and ≥ 95%	25%	25%	25%
< 95% and ≥ 90%	50%	50%	50%
< 90% and ≥ 85%	75%	75%	75%
< 85%	100%	100%	100%

3-10.i.5 Risk and Bonus Payout Reconciliation

The administrative fee will be paid in full on a monthly basis until such time the Evaluation Periods have occurred and determination has been made regarding the CONTRACTOR's compliance. Reconciliation of the administrative fees shall occur two (2) times a year on January 1 and July 1. Payouts for determinations that have been made for the 1st and 2nd Quarters shall be made by January 1 of the following year and payouts for determinations that have been made for the 3rd and 4th Quarters shall be made by July 1 of the following year.

In the event that the CONTRACTOR's progress on the various initiatives are different from what is determined by TennCare, the results (findings from both) will be reconciled during a fifteen (15) business day period following the due date of the submission by the Plan. If the dispute relates to medical cost and utilization based initiatives, TENNCARE shall request review by the Department of the Comptroller of the Treasury of said discrepancies. TennCare will submit an "On Request Report" (with a seven (7) day response time) to the CONTRACTOR in order for the CONTRACTOR to review and update or reprocess their data provided to TENNCARE. TENNCARE shall provide the outcome of the determination within eight (8) business days of receiving the information from the CONTRACTOR. If the information requested by TENNCARE is not provided by the due date, then the determination defaults to TENNCARE.

If targets are consistently exceeded (or not met) TENNCARE shall require that the CONTRACTOR submit a Corrective Action Plan to address the deficiencies.

3-10.i.6 Payment for Covered Services

Effective July 1, 2005, the CONTRACTOR shall not be at financial risk for the cost of covered services incurred by TennCare enrollees provided in accordance with the Amended and Restated Contractor Risk Agreement, as amended. This provision shall not relieve the CONTRACTOR from its responsibility to arrange for services in accordance with the terms of said Agreement, including requirements for timely claims processing specified in Section 2-9.m. Payment for covered services shall be made as follows:

3-10.i.6(a) Payment Requirements

The CONTRACTOR shall continue to reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002 for covered services as defined in Section 3-10.i.6(i), unless otherwise directed by TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider. The CONTRACTOR shall assure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 2-18 of this Agreement.

3.10.i.6(b) Provider Payment Process

The CONTRACTOR shall prepare checks for payment of providers for the provision of covered services incurred on or after the implementation date of this provision on a weekly basis, unless an alternative payment schedule is approved by TENNCARE. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable

form and substance at least 72 hours in advance of distribution of provider checks. The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 72 hours of receipt of notice. In turn, the CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State and provide TENNCARE with a check register or similar document that is generated from the managed care claims processing system supporting the release of these payments by no later than seven (7) calendar days after the CONTRACTOR's request of the funds.

For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and media described by TENNCARE to support the payments released to providers. The CONTRACTOR should provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within seven (7) days of the claims data extract.

Upon notification by TENNCARE, funds released to the CONTRACTOR for purposes of provider payments shall be made based on the CONTRACTOR's encounter data. TENNCARE shall implement this process by initially making payments based on all encounters and providing the CONTRACTOR an error report of unacceptable encounter records. The final phase of implementation shall result in TENNCARE releasing funds based on clean encounters only. Once TENNCARE releases funds based solely on clean encounter data, the CONTRACTOR will no longer be required to submit the claims data extract. The reconciliation and check register must continue to be submitted on a weekly basis for the previous weeks check release.

The CONTRACTOR shall pursue and report on providers which maintain an accounts-payable balance or maintain outstanding checks in accordance with Section 2-10.e.3 of this Agreement.

3-10.i.6(c) 1099 Preparation

The CONTRACTOR shall prepare and submit 1099 Internal Revenue Service reports for all providers to whom payment is made.

3-10.i.6(d) Interest

Interest generated from the deposit of funds specified in Section 3-10.i.6(a) for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the CONTRACTOR's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

3-10.i.6(e) Third Party Liability (TPL) Resources

The CONTRACTOR shall be required to seek and collect third party subrogation amounts regardless of the amount available or believed to be available as required by federal guidelines. The amount of provider payments specified in Section 3-10.g.6(a) shall be net of third party recoveries captured on the CONTRACTOR's claims processing system prior to notification of TENNCARE of the amount to be paid. The

CONTRACTOR shall post all third party payments to claim level detail by enrollee. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the claims processing system shall also be the property of the State. On a monthly basis, the CONTRACTOR shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request/encounter submission (when applicable) subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported. Further, the CONTRACTOR shall provide any information necessary in a format and media described by TENNCARE and shall cooperate as requested by TENNCARE, with TENNCARE and/or a Cost Recovery Vendor at such time that TENNCARE acquires said services.

Failure to seek, make reasonable effort to collect and report third party recoveries shall result in liquidated damages as described in Section 4-8 of this Agreement. It shall be the CONTRACTOR's responsibility to demonstrate, upon request, to TENNCARE that reasonable effort has been made to seek, collect and/or report third party recoveries. TENNCARE shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated.

3-10.i.6(f) Reinsurance recoveries

In the event the CONTRACTOR maintains an aggregate or stop-loss reinsurance policy, the CONTRACTOR shall reduce the total amount of the invoice to be paid by TennCare by the net amount of any reinsurance recoveries applicable to claims with dates of service after July 1, 2002. Furthermore, the CONTRACTOR agrees to cancel or retain a reinsurance policy during the Stabilization Period upon direction from TennCare.

For MCOs who have reinsurance policies in effect, the CONTRACTOR shall reconcile their claims payments against the terms of their reinsurance policy for appropriate action and shall provide TENNCARE with quarterly reports that reflect the CONTRACTOR's findings and actions.

3-10.i.6(g) HMO Payment Tax

Payments to the CONTRACTOR shall be increased sufficiently to cover any additional amount due pursuant to Tennessee Code Annotated Section 56-32-224 thirty days after the end of each calendar year quarter. The CONTRACTOR shall be responsible for payment of applicable taxes pursuant to TCA 56-32-224. In the event the amount due pursuant to TCA 56-32-224 is increased during the term of this Agreement, the payments to the CONTRACTOR shall be increased by an amount equal to the increase in the amount due by the CONTRACTOR.

3-10.i.6(h) Service Dates

Except where required by the CONTRACTOR's Agreement with TennCare or by applicable federal or state law, rule or regulation, the CONTRACTOR shall not make payment for the cost of any medical care provided prior to the effective date of eligibility or after the termination date in the CONTRACTOR's plan. The CONTRACTOR shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the CONTRACTOR's plan.

3-10.i.6(i) Covered Services

The State shall only assume responsibility for payment of providers for the provision of covered services as specified in Section 2-3 and payment of providers or enrollees in response to a directive from TennCare or an Administrative Law Judge. Otherwise, in the event the CONTRACTOR makes payment for a non-covered service, the State shall not be responsible for the payment of said service.

3-10.i.6(j) Cost-Sharing

Payments for covered services specified in Section 3-10.i.6(a) shall not include payment for enrollee cost-sharing amounts.

i. The claims payment amount shall be net of any amounts that the provider is entitled to collect pursuant to applicable coordination of benefits rules.

ii. When eligibility has been established by TENNCARE and the enrollee has incurred medical expenses that are covered benefits within the plan, the CONTRACTOR shall make reimbursement for the medical services at the regular negotiated rate if the service was provided by a contract provider. If the service was provided by a non-contract provider, the CONTRACTOR shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure except for applicable TennCare cost share amounts. The CONTRACTOR shall require, as a condition of payment, that the service provider accept the amount paid by the CONTRACTOR or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the enrollee's third party payor) plus any applicable amount of TennCare cost share amounts due from the enrollee as payment in full for the covered service.

iii. If a provider seeks reimbursement for a service provided during a retroactive period of eligibility, the CONTRACTOR shall assess cost-sharing responsibilities in accordance with the cost-sharing schedules in effect on the date of service for which reimbursement is sought (See Attachment X.C). If the CONTRACTOR had a TennCare Bureau approved alternative cost-share schedule in place during this retroactive period of eligibility, the CONTRACTOR may apply its alternative schedule.

3-10.i.7. Disallowances

The CONTRACTOR shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with the requirements of this Agreement, including but not limited to, requirements to pay providers in accordance with reimbursement rates and medical management polices and procedures in effect as of April 16, 2002, as specified in Section 2-9, as amended, unless otherwise approved or directed by TENNCARE. In the event TENNCARE determines a cost was not incurred in accordance with this Agreement, TENNCARE reserves the right to disallow said cost and reduce the amount of future fixed administrative fee payments by the amount of the disallowance. The CONTRACTOR shall provide TENNCARE and/or an auditor for the TennCare Program access to all information necessary to perform the examination. In the event that a future fixed administrative fee payment is not scheduled at the time a disallowance is

identified, or the amount of the disallowance exceeds the amount of the fixed administrative rate payment, the CONTRACTOR shall reimburse the State for the amount of the disallowance within thirty (30) calendar days of receipt of written notice.

3-10.i.8. Provider Reimbursement

The CONTRACTOR must agree to reasonable reimbursement standards to providers for covered medical services, to be determined in conjunction with actuarially sound rate setting. All reimbursement paid by CONTRACTOR to providers and amounts paid by the CONTRACTOR to any other entity is subject to audit by the State. At such time that TENNCARE develops a provider fee schedule for use by all of the TennCare MCOs, the CONTRACTOR shall agree to implement, within a reasonable timeframe, said fee schedule.

The CONTRACTOR shall not pay more for similar services rendered by any provider or subcontractor that has an indirect ownership interest or an ownership or control interest in the MCO or an MCO's affiliates or an MCO's management company than the CONTRACTOR pays to providers and subcontractors that do not have an indirect ownership interest or an ownership or control interest in the MCO, an MCO's affiliates or an MCO's management company for similar services. The standards and criteria for determining whether a provider or a provider subcontracting entity or a subcontractor has an indirect ownership interest, an ownership interest or a control interest are set out at Title 42, Part 455, Subpart B of the Code of Federal Regulations.

Any payments made by the CONTRACTOR that exceed the limitations set forth in this Section shall be reduced from total expenditures prior to the State sharing costs for covered services. No later than fifteen (15) days following the end of each calendar quarter, the CONTRACTOR shall submit: (1) a list of all related providers and subcontractors with which the CONTRACTOR has contracted during the preceding calendar quarter, and (2) a detailed explanation verifying that the payments made to such related providers and subcontractors are not in excess of the amounts allowed by this paragraph.

3-10.i.9. Effect of Disenrollment on the Fixed Administrative Fee Payments

Payment of the fixed administrative fee shall cease on the effective date of disenrollment and the CONTRACTOR shall have no further responsibility for the care of the enrollee. TENNCARE shall adjust administrative fees to reflect the effective date of disenrollment. Except for situations involving enrollment obtained by fraudulent applications or death, disenrollment from TennCare shall not be made retroactively. The CONTRACTOR shall not be required to refund any administrative fee payments legitimately paid pursuant to this Agreement. In the case of fraudulent, misrepresented or deceptive applications submitted by the enrollee, the CONTRACTOR, at its discretion, may refund to TennCare all fixed administrative fee payments made on behalf of persons who obtained enrollment in TennCare through such means and the CONTRACTOR shall make a good faith effort to pursue full restitution for all payments made for medical care while the person was inappropriately enrolled in the CONTRACTOR's plan. In the event of enrollment obtained by fraud, misrepresentation or deception of individuals by the CONTRACTOR's staff, officers, employees, providers, volunteers, subcontractors, or anyone acting for or on behalf of the CONTRACTOR, TENNCARE may retroactively recover fixed administrative fee payments and payments for covered services incurred by the enrollee plus interest, as allowed by TCA 47-14-103, and any other monies paid to any managed care organization for the enrollment of that individual. The refund of payments plus interest will not

preclude the State from exercising its right to criminal prosecution, civil penalties, trebled damages and/or other remedial measures.

3-10.i.10. Additional Payment for Specified Achievement Level of Initial NCQA Accreditation

In addition to the fixed administrative fee specified in Section 3-10.i, the CONTRACTOR may obtain additional payments for the successful achievement of initial NCQA Accreditation.

PERFORMANCE MEASURE	MEASUREMENT	POTENTIAL PAY-OUT	PAY-OUT FORMULA	DATA SOURCE
NCQA Accreditation Status	NCQA Accreditation Status Achieved: 1. Excellent 2. Commendable 3. Accredited 4. Provisional 5. Denied	Initial Accreditation Fees that qualify as reimbursable: Application and Pre-Survey Fee, Base Survey Fee, and the additional Per Member Fee **NOTE: Proof of payment to NCQA will be required for reimbursement**	Reimbursed at the following rates: 1. Excellent – 100% 2. Commendable – 80% 3. Accredited – 60% 4. Provisional – 40% 5. Denied – 0 **NOTE: Fees associated with resurveys within three years of the initial accreditation status determination will not be reimbursed.**	NCQA Final Accreditation Status Report

Payout for reimbursable expenses shall occur within thirty (30) days of receipt by TENNCARE of proof of the CONTRACTOR's NCQA paid invoice.

3-10.i.11. Pay-for-Performance Administrative Fee for Disease Management (DM)

1. Depending of the level of performance, the CONTRACTOR may earn up to $0.12 pmpm in the form of a supplemental administrative fee for disease management.

On July 1, 2006, the CONTRACTOR will be eligible for an additional $0.03 pmpm, applied to member months from the period of July 1, 2005 to June 30, 2006, if their HEDIS 2006 HbA1c testing rate is at or above the 50th percentile for Medicaid HEDIS 2005, as reported by NCQA. In addition, on July 1, 2006, the CONTRACTOR will be eligible for an additional $0.03 pmpm, applied to member months from the period of July 1, 2005 to June 30, 2006, if their HEDIS 2006 Prenatal Care rate is at or above the 75th percentile for Medicaid HEDIS 2005, as reported by NCQA.

On December 31, 2006, the CONTRACTOR will report the following ED utilization data to TENNCARE:

1. Emergency department visits with a diagnosis of asthma divided by total number of enrollees in the MCO with a diagnosis of asthma, multiplied by 1000 for the time periods July 1 – September 30 in calendar year 2005 and in calendar year 2006.

2. Emergency department visits with a diagnosis of congestive heart failure divided by total number of enrollees in the MCO with a diagnosis of congestive heart failure, multiplied by 1000 for the time periods July 1 – September 30 in calendar year 2005 and in calendar year 2006.

Emergency Department visits shall include all ER visits even if the visit results in a 23 Hour Observation or an inpatient stay. Include Emergency Department visits whether or not an actual payment to the provider was made for the services.

The CONTRACTOR will be eligible for an additional $0.03 pmpm, applied to member months from the period of January 1, 2006 to December 31, 2006, if the ED visit rate per 1000 for asthma has decreased by at least 5% from 2005. Similarly, the CONTRACTOR will be eligible for an additional $0.03 pmpm, applied to member months from the period of January 1, 2006 to December 31, 2006, if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5% from 2005.

Beginning on July 1, 2007, the supplemental administrative fee will be referred to as a Quality Incentive and will be based on HEDIS, CAHPS and/or utilization criteria specified by TennCare and assessed annually. The CONTRACTOR will be advised of the specific methodology that will be used for the July 1, 2007 supplemental fee determination, by September 1, 2006.

The CONTRACTOR's eligibility for the supplemental administrative fee payment described in this Section shall not adjust the base administrative fee described in Attachment X of this Agreement for effective dates not described in this Section 3-10.i.11.

32. Section 4-7 shall be deleted and replaced in its entirety so that the amended Section 4-7 shall read as follows:

4-7. Conflict of Interest

(a) The CONTRACTOR warrants that no part of the total Agreement amount provided herein shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. The authorization may be requested in writing to the Commissioner of Finance and Administration. (See 45 CFR 93.100 *et seq.*, 31 USC 1352, TCA 3-6-101 *et seq.*, 3-6-201 *et seq.*, 3-6-301 *et seq.*, and 8-50-505.)

(b) By December 31 of each year disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Bureau of TennCare, Department of Finance and Administration in writing. The disclosure shall include the following:

1. A list of any officer or employee of the State of Tennessee who receives wages or compensation in connection with work performed under this Agreement;

2. A statement of the reason or purpose for the wages or compensation; and

3. A statement that the Commissioner of Department of Finance and Administration has authorized this arrangement.

(c) This Agreement may be terminated by TENNCARE if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any officials or employees of the State of Tennessee. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Agreement.

The CONTRACTOR shall include the substance of this clause in all subcontracts and provider agreements.

33. The Liquidated Damages chart of Program Issues in Section 4-8.b.2 shall be deleted and replaced in its entirety so that the amended Chart of Liquidated Damages shall read as follows:

CLASS	PROGRAM ISSUES	DAMAGE
A.1	Failure to comply with claims processing as described in Section 2-2.h and 2-9.m of this Agreement	$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2-2.h and 2-9.m of this Agreement.
A.2	Failure to comply with licensure requirements in Section 2-9.d of this Agreement	$5,000 per calendar day that staff/provider/agent/subcontractor is not licensed as required by applicable state law plus the amount paid to the staff/provider/agent/subcontractor during that period
A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child at risk of entering DCS custody as described in Section 2-3.c.1 of this Agreement	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater, to be deducted from monthly fixed administrative fee payments.
A.4	Failure to comply with obligations and timeframes in the delivery of EPSDT screens and related services	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater, to be deducted from monthly fixed administrative fee payments.
A.5	Denial of a request for services to a child at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer	The actual amount paid by DCS and/or TENNCARE for necessary services or $1000, whichever is greater, to be deducted from monthly fixed administrative fee payments.

CLASS	PROGRAM ISSUES	DAMAGE
A.6	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TENNCARE to do so or upon approval of the service or payment by the CONTRACTOR during the appeal process, or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of good cause.	$500 per day beginning on the next calendar day after default by the plan in addition to the cost of the services not provided.
A.7	Failure to provide proof of compliance to the Bureau Office of Contract Compliance and Performance within five (5) calendar days of a reasonable and appropriate directive from TennCare or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of Good Cause.	$500 per day beginning on the next calendar day after default by the plan.
A.8	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/ Hysterectomies as outlined in Section 2-3.o of this Agreement	$500 per violation or the actual amount of the federal penalty created by this violation, whichever is greater.
A.9	Failure to provide coverage for prenatal care without a delay in care and in accordance with the terms of this Agreement	$500 per day, per occurrence, for each day that care is not provided in accordance with the terms of this Agreement.
A.10	Failure to comply with the notice requirements of the TENNCARE rules and regulations or any subsequent amendments thereto, and all court orders governing appeal procedures, as they become effective.	$500 per occurrence in addition to $500 per calendar day for each calendar day required notices are late or deficient or for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE

CLASS	PROGRAM ISSUES	DAMAGE
A.11	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by the TENNCARE rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.	An amount sufficient to at least offset any savings the CONTRACTOR achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense. $500 per day for each calendar day beyond the 2nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE.
A.12	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days.	$500 per calendar day.
A.13	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective.	$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE.
A.14	Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member.	$1,000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of $500 ($500 for the first day, $1,000 for the second day, $1,500 for the third day, etc.) for each day the notice is late and/or remains defective.

CLASS	PROGRAM ISSUES	DAMAGE
A.15	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective.	First occurrence: $500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, $500 per notice even if a corrected notice was issued upon request by TENNCARE). Damages per instance shall increase in $500 increments for each subsequent "systemic problem or violation of the law" ($500 per instance the first time a "systemic problem or violation of the law" relating to a particular requirement is identified; $1,000 per instance for the 2nd time a "systemic problem or violation of the law" relating to the same requirement is identified; etc.)
A.16	Systemic violations regarding any aspect of the requirements in accordance with this Agreement and the TennCare rules and regulations.	First occurrence: $500 per instance of such systemic violations, even if damages regarding one or more particular instances have been assessed. Damages per instance shall increase in $500 increments for each subsequent systemic violation ($500 per instance the first time a systemic violation relating to a particular requirement is identified; $1,000 per instance for the 2nd time a systemic violation relating to the same requirement is identified; etc.)
A.17	Failure to adhere to ED guidelines as described in Section 2-3.s.5 of this Agreement.	$1000 per occurrence for each failure to enroll a member identified per 2-3.s.5 in active case management. $5000 per occurrence for each failure to assist a member in arranging care in an alternative setting per 2-3.s.5 (g) or (h).

CLASS	PROGRAM ISSUES	DAMAGE
A.18	Failure to 1) provide an approved service timely, i.e., in accordance with timelines specified in the Special Terms and Conditions for Access in the TennCare Waiver or Attachment III, or when not specified therein, with reasonable promptness; or 2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service.	The cost of services not provided plus $500 per day, per occurrence, for each day 1) that approved care is not provided timely; or 2) notice of delay is not provided and/or the MCC fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service.
B.1	Failure to report Specialty listings to PCP providers as required by this Agreement.	$500 per calendar day.
B.2	Failure to complete or comply with corrective action plans as required by TENNCARE.	$500 per calendar day for each day the corrective action is not completed or complied with as required.
B.3*	Failure to comply with the approved expenditure plan in effect after July 1, 1999 as required by Section 3-10.b of the Contractor Risk Agreement dated September 11, 1995 in accordance with Section 1-7 and Attachment XIV of this Agreement.	$15,000 per calendar day for each calendar day of non-compliance plus the amount that was not expended as required by the approved expenditure plan.
B.4	Failure to seek, collect and/or report third party recoveries to TENNCARE.	$500 per day for each calendar day that TENNCARE determines the CONTRACTOR is not making reasonable effort to seek and collect third party recoveries.
B.5	Deadlines for Achieving NCQA Accreditation.	Termination of the Agreement for Breach as described in Section 4-2 for consistent failure to meet the deadlines described in Section 2-9.j.7 of this Agreement.
B.6	Failure to submit Audited HEDIS and CAHPS Reports Annually by June 15th as described in Section 2-9.j.7 and 2-10.m.4.	$250 per day for every calendar day reports are late.

CLASS	PROGRAM ISSUES	DAMAGE
B.7	Failure to submit NCQA Accreditation Report as described in Sections 2-9.j.7 and 2-10.m.6.	$500 per day for every calendar day beyond the 10th calendar day Accreditation Status is not reported.
B.8	Failure to comply with Conflict of Interest, Lobbying, and Gratuities requirements described in Section 4-7, 4-11 or 4-12.	110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals as described in Section 4-7, 4-11 or 4-12 and possible termination of the Agreement as described in 4-7, 4-11 or 4-12.
B.9	Failure to submit TennCare Disclosure of Lobbying Activities Form by CONTRACTOR	$1000.00 per day that disclosure is late
B.10	Failure to comply with Offer of Gratuities constraints described in Section 4-11	110 % of the total benefit provided by the CONTRACTOR to inappropriate individuals and possible termination of the Agreement for Breach as described in 4-2 of this Agreement.
B.11	Failure to obtain approval of Marketing Materials.	$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided enrollee material that has not been approved by TENNCARE.
B.12	Failure to comply with Marketing timeframes for providing Member Handbooks, I.D. cards, Provider Directories, and Newsletters.	$5000 for each occurrence.
B.13	Failure to achieve and/or maintain financial reserves in accordance with TCA.	$500 per calendar day for each day that financial requirements have not been met.
B.14	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.10.h.2.	$500 per calendar day.
B.15	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.10.h.3.	$500 per calendar day.

CLASS	PROGRAM ISSUES	DAMAGE
B.16	Failure to submit audited financial statements as described in Section 2.10.h.4.	$500 per calendar day.
B.17	Failure to comply with fraud and abuse provisions as described in Section 1-5 of this Agreement.	$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions described in Section 1-5 of this Agreement.
B.18	Failure to send collection notices to providers as described in 2-10.e.3(a) of this Agreement.	$100 per provider notice per month.
B.19	Failure to send detailed reports to TENNCARE as described in 2-10.e.3(b), (c) and (d) of this Agreement.	$500 per day for each day that report is late.
B.20	Failure to require and assure compliance with Ownership and Disclosure requirements.	$5000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B.
B.21	Failure to maintain a complaint and appeal system as required in Section 2-8 of this Agreement.	$500 per calendar day
B.22	Failure to maintain required insurance as required in Section 2-20 of this Agreement.	$500 per calendar day
B.23	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2.-3.a.3 and 2-3.s of this Agreement.	$500 per occurrence.

CLASS	PROGRAM ISSUES	DAMAGE
B.24	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application as required in Section 2-3.k.6 and 2-9.j.6 of this Agreement.	$5000 per application that has not been approved and loaded into the CONTRACTOR's system or denied within thirty (30) calendar days of receipt of a completed credentialing application. And/Or $1000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been completed as described in Section 2-3.k.6 and 2-9.j.6 of this Agreement.
B.25	Failure to maintain provider agreements in accordance with Section 2-18 of this Agreement.	$5000 per provider agreement found to be non-compliant with the requirements outlined in Section 2-18 of this Agreement.
C.1	Failure to comply in any way with staffing requirements as described in Section 2-9.c of this Agreement.	$250 per calendar day for each day that staffing requirements as described in Section 2-9.c of this Agreement are not met.
C.2	Failure to report provider notice of termination of participation in the CONTRACTOR's plan.	$200 per day.
C.3	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE.	An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE.

34. Section 4-12 shall be deleted and replaced in its entirety so that the amended Section 4-12 shall read as follows:

4-12. Lobbying

The CONTRACTOR certifies by signing this Agreement, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. (See also TCA 3-6-101 *et seq.*, 3-6-201 *et seq.*, 3-6-301 *et seq.*, and 8-50-505.).

The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

Failure by the Contractor to comply with the provisions herein shall result in termination of the Contract and/or liquidated damages as provided in 4-8.b.2 (B.8 and B.99) of this Agreement.

35. Attachment II shall be deleted in its entirety and shall now read "Left Blank Intentionally".

36. Attachment X shall be amended by adding a new table X.D.3 which shall read as follows:

Table X.D.3 Administrative Rates Effective July 1, 2006

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	$11.57
100,000 to 199,999 enrollees	$11.45
200,000 to 299,999 enrollees	$11.32
300,000 to 399,999 enrollees	$11.20
400,000 to 499,999 enrollees	$11.09
500,000 to 599,999 enrollees	$10.88
600,000 to 699,999 enrollees	$10.73
700,000 to 799,999 enrollees	$10.58
800,000 to 899.999 enrollees	$10.43
900,000 to 999,999 enrollees	$10.28
1,000,000 or more enrollees	$10.13

37. Attachment XII, Exhibit C shall be deleted in its entirety and shall be replaced with a new Exhibit C which shall read as follows:

ATTACHMENT XII, EXHIBIT C
REQUIRED DATA ELEMENTS FOR PROVIDER ENROLLMENT REPORTING

This provider listing shall include, at a minimum, the following data elements:

1. Provider name;
2. Provider address, including the address of all service sites operated by the provider (a P.O. Box is not acceptable);
3. Tax/Employer I.D. number (EIN) or Provider social security;
4. Provider's race and/or national origin;
5. Provider Specialty 1and Specialty 2;
6. Provider license number and type of license (if applicable);
7. Tennessee Medicaid Provider I.D. Number for the individual provider being enrolled (Should correspond to the Provider Name) .;
8. Unique Individual MCC Provider I.D. Number (Should correspond to the Provider Name);
9. Medicare I.D. number, if applicable (Should correspond to the Provider Name);

10. Initial Credentialing Date;

11. Recredentialing Date (This date must reflect the actual date recredentialing completed);

12. Provider telephone number (including area code) for each provider service site (up to 6 phone numbers);

13. Provider's Drug Enforcement Agency (DEA) number (if applicable);

14. Begin date of participation and end date of participation (if applicable);

15. Contracted Provider versus Non-Contracted Provider Indicator (single case agreements are considered Non-Contracted Providers);

16. Indicate whether or not the following services are provided by the provider: Obstetrics, General Surgery, Pediatrics, or EPSDT;

17.. Is the provider board certified;

18. The provider's service delivery county of practice; and

19. Indicate whether or not the provider's practice is limited to male or female patients;

20. Date disclosure form/attestation signed by provider;

For Dentists and Primary Care Providers (PCP) the following additional data elements are required:

21. Is the Dental / PCP's practice closed to new TennCare members as primary care patients;

For Primary Care Providers (PCPs only) the following additional data elements are required:

22. Does the PCP deliver babies;

23. Does the PCP provide prenatal care;

24. What is the youngest age each individual PCP will accept as a patient into the PCP's practice? (Age zero (00) equates to providing services to newborns);

25. What is the oldest age each individual PCP will accept as a patient into the PCP's practice? (Age 99 equates to Age 99 and older); and

26. How many members has the MCO assigned to each individual PCP for primary care service delivery?

38. Attachment XII, Exhibits L.1 through L.3 shall be amended by deleting the words "Cumulative Year to Date" from the Header of each reporting format.

39. This Agreement shall be amended by deleting the words "Office of Contract Development and Compliance (OCDC) and replacing them with "Office of Contract Compliance and Performance (OCCP)".

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2006 or as of the effective date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
M. D. Goetz, Jr.
Commissioner

DATE: _____

MCO NAME

BY: _____
Name
Title

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
M. D. Goetz, Jr.
Commissioner

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
John G. Morgan
Comptroller

DATE: _____